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CHAPTER FIFTY-ONE

HOSPICE CARE

Chapter 51. Hospice Care.

Rule No. 560-X-51-.01. Hospice Care - General.

(1) Hospice care services are available if medically necessary for all Medicaid eligible recipients certified as being terminally ill. Medical certification is required by the individual's attending physician; however, if the recipient does not have a primary attending physician, certification may be given by the Hospice Team physician or the hospice medical director. Certification of the terminal illness of an individual who elects hospice shall be based on the attending physician, hospice team physician, or hospice medical director's clinical judgement regarding the normal course of the individual's illness. Certifications of terminal illness must include specific findings and other medical documentation including, but not limited to, medical records, lab x-rays, pathology reports, etc. Hospice care means services which are necessary for the palliation or management of the terminal illness and related conditions.

(2) Alabama Medicaid Hospice Care services are subject to Medicare special election periods applicable to hospice care. Medicaid will utilize the most recent benefit periods established by the Medicare Program.

Author: LaShawn Anthony, Administrator, LTC Project Development/Policy Unit, Long Term Care Division
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.20; State Medicaid Manual; and State Plan.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991 and September 9, 1998. Amended: Filed March 20, 2001; effective June 20, 2001.

Rule No. 560-X-51-.02. Definitions.

(1) Hospice means a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices and has a valid Medicaid provider agreement.

(2) Attending physician means a doctor of medicine or osteopathy who is identified by the individual at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care.

(3) Election statement means a written statement electing hospice care filed by a recipient, or his representative, with a hospice.

(4) Election period means one of four periods for which an individual may elect to receive Medicaid coverage of hospice care during the individual's lifetime.

(5) Employee means an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" also refers to a volunteer under the jurisdiction of the hospice.

(6) Interdisciplinary team means a group of persons employed by the hospice which includes at least:

(a) One physician
(b) One registered nurse
(c) One social worker
(d) One pastoral or other counselor.

(7) Plan of care means a written plan of care established by the attending physician, the medical director, or physician designee and interdisciplinary team prior to providing care.

(8) Terminally ill means that the individual has a medical prognosis that his or her life expectancy is six months or less.

(9) Representative means a person who, because of the terminally ill individual's mental or physical incapacity, is authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of that individual.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.3 and Section 418.68; and State Plan. Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991.

Rule No. 560-X-51-.03. Provider Eligibility and Certification of Terminal Illness Requirements.

(1) A provider of hospice services shall meet the definition of hospice in Rule No. 560-X-51-.02(1).

(2) The provider shall participate in Title XVIII (Medicare) and shall be certified under Medicare standards.

(3) Within two days after hospice care is initiated, the provider shall obtain terminally ill certification statements on all recipients and shall maintain them for the duration of hospice care. If the hospice does not obtain a written certification as described, verbal certification may be obtained, but written certification must be obtained no later than eight (8) days after care is initiated. For each subsequent period, the hospice must obtain written certification within two (2) calendar days of the beginning of the period. The hospice must not recertify an individual who reaches a point of stability and is no longer considered terminally ill. The individual must return to traditional Medicaid benefits. Patients requiring services that are not for the palliation or management of

terminal illness or related condition must also be discharged to traditional Medicaid benefits.

(4) All services shall be provided under a written plan of care established and maintained for each individual admitted to a hospice program, and the care provided shall be in accordance with the plan.

(5) In addition to the completion of a provider enrollment agreement, a hospice must also submit the following information to the Alabama Medicaid Agency's fiscal agent:

(a) A letter from the State licensing unit showing the permit number and effective date of permit.

(b) A document from the licensing unit showing that the hospice meets requirements for the Medicare program.

(c) A signed document indicating that the hospice is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

(d) A copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved reimbursement rate, the fiscal year end, and the Medicare provider number.

(6) The hospice provider must verify the recipient's Medicaid eligibility. The provider must designate the hospice election by placing a label on the Medicaid card to notify other providers of waived services. If the election ends, the hospice provider will remove the label to notify all providers that services are no longer waived.

(7) The hospice must complete required hospice election and physician certification documentation Medicaid coverage of hospice care. This information shall be kept on file and shall be made available to the Alabama Medicaid Agency for auditing purposes. The Long Term Care Admissions/Records Unit will perform random audits on a percentage of records to ensure that documentation supports the medical level of care criteria, physician certification, as well as other state and federal requirements.

(8) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

Author: Marilyn Ferguson, Director, Long Term Care Division.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.20 and Section 418.22; OBRA '90; State Medicaid Manual; and State Plan.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991, January 13, 1993, and October 1, 1993. **Amended:** Filed March 20, 2001; effective June 20, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003.

Rule No. 560-X-51-.04. Recipient Eligibility.

In order to be eligible to elect hospice care under Medicaid, an individual must be:

(1) Medicaid eligible.

(2) Certified by a physician as terminally ill and require hospice services which are medically necessary for the palliation or the management of the terminal illness and conditions related to the terminal illness. Certification of terminal illness must include specific clinical findings and other medical documentation including, but not limited to, medical records, lab x-rays, pathology reports, etc. A person who reaches a point of stability and is no longer considered terminally ill must not be recertified for hospice services. The individual must be discharged to traditional services. Medicaid eligibility for the Hospice program, for recipients who are not dually eligible for Medicare, is based upon financial and medical criteria. The following medical criteria must be present for the terminal illnesses listed below. For diagnoses not found in the Alabama Medicaid Agency administrative code or for pediatric cases medical necessity review will be conducted on a case-by-case basis.

(a) *Hospice Criteria for Adult Failure to Thrive Syndrome*

1. Terminal Illness Description: The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition and disability. The syndrome has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes two defining clinical elements, namely nutritional impairment and disability. The nutritional impairment and disability associated with the adult failure to thrive syndrome may be severe enough to impact the patient's short-term survival. The adult failure to thrive syndrome may manifest as an irreversible progression in the patient's nutritional impairment/disability despite a trial of therapy (i.e., treatment intended to affect the primary condition responsible for the patient's clinical presentation).

2. Indications/Criteria: Criteria below must be present at the time of initial certification or re-certification for hospice. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. Patients must meet **(i) and (ii)** below:

(i) The nutritional impairment associated with the adult failure to thrive syndrome must be severe enough to impact a beneficiary's weight. It is expected that the Body Mass Index (BMI) of beneficiaries electing the Medicaid Hospice Benefit for the adult failure to thrive syndrome will be below 22 kg/m^2 and that the patient is either declining enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake and **must show > 10 % weight loss in the 90 day period immediately preceding Medicaid election of the hospice benefit**.

(ii) The disability associated with the adult failure to thrive syndrome should be such that the individual is significantly disabled. Significant disability would be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%.

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(b) Hospice Criteria for Adult HIV Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Indications/Criteria: Criteria below must be present at the time of initial certification or re-certification for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria:

HIV Disease (**i) and (ii)** must be present; factors from (iii) will add supporting documentation)

(i) CD4+ Count <25 cells/mcL or persistent viral load>100,000 copies/ml, plus ***one*** of the following:

(I) CNS lymphoma

(II) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass)

(III) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused

(IV) Progressive multifocal leukoencephalopathy

(V) Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy

(VI) Visceral Kaposi's sarcoma unresponsive to therapy

(VII) Renal failure in the absence of dialysis

(VIII) Cryptosporidium infection

(IX) Toxoplasmosis, unresponsive to therapy

(ii) Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of ≤ 50

(iii) Documentation of the following factors will support eligibility for hospice care:

(I) Chronic persistent diarrhea for one year

(II) Persistent serum albumin <2.5

(III) Age > 50 years

(IV) Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease

(V) Advanced AIDS dementia complex

(VI) Toxoplasmosis

(VII) Congestive heart failure, symptomatic at rest, New York Heart Association (NYHA) classification Stage IV

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy

(ii) Absence of supporting documentation of progression or rapid decline

(iii) Failure to document terminal status of six months or less.

(iv) Patient on protease inhibitors.

(c) Hospice Criteria for Adult Pulmonary Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Indicators/Criteria: Criteria below must be present at the time of initial certification or re-certification for hospice. Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease (**i) and (ii)** must be present; documentation of (iii), (iv) and/or (v) will lend supporting documentation:

(i) Severe chronic lung disease as documented by both factors below:

(I) Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough (documentation of Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicated is objective evidence for disabling dyspnea, must be provided).

(II) Progression of end stage pulmonary disease, as evidenced by 6 or more visits to the emergency room within the last 12 months, or 2 or more hospitalizations for pulmonary infections and/or respiratory failure, or one or more Intensive Care Unit admissions within the last six months. **The hospitalizations or emergency room visits must be related to the terminal illness** (documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain).

(ii) Hypoxemia at rest on room air, with a current ABG and PO2 at or below 59 mm Hg or oxygen saturation at or below 89% taken at rest may be obtained either from recent hospital records or hypercapnia, as evidenced by $PCO2^{3} \geq 50$ mmHg (this value may be obtained from recent hospital records).

(iii) Cor pulmonale and right heart failure (RHF) secondary to pulmonary disease (e.g., not secondary to left heart disease or valvulopathy).

(iv) Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

(v) Resting tachycardia >100/min.

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(d) Hospice Criteria for Adult Alzheimer's Disease & Related Disorders

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Alzheimer's disease and related disorders is further substantiated with medical documentation of a progressive decline in the Reisburg Functional Assessment Staging (FAST) Scale, within a six month period of time, prior to the Medicaid hospice election.

2. Indications/Criteria: Criteria below must be present at the time of initial certification or re-certification for hospice. Alzheimer's disease and related disorders may support a prognosis of six months or less under many clinical scenarios. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by co morbid and/or secondary conditions. Co-morbid conditions affecting beneficiaries with Alzheimer's disease are by definition distinct from the Alzheimer's disease itself- examples include coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Secondary conditions on the other hand are directly related to a primary condition – in the case of Alzheimer's disease examples include delirium and pressure ulcers. The Reisberg Functional Assessment Staging (FAST) Scale has been used for many years to describe Medicare beneficiaries with Alzheimer's disease and a prognosis of six months or less. The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's disease. Stage 7 identifies the threshold of activity limitation that would support a six-month prognosis; however all sub stage fast scale indicators under stage 7 must be present. The FAST Scale does not address the impact of co- morbid or secondary conditions. The presence of secondary conditions is thus considered separately by this policy and **(i)** must be present; factors from (ii) will add supporting documentation. The FAST Scale is designed to parallel the progressive activity.

(i) To be eligible for hospice beneficiaries with Alzheimer's disease must have a FAST level of greater than or equal to 7.

FAST Scale Items:

Stage #1: No difficulty, either subjectively or objectively

Stage #2: Complains of forgetting location of objects; subjective work difficulties

Stage #3: Decreased job functioning evident to coworkers; difficulty in traveling to new locations

Stage #4: Decreased ability to perform complex tasks (e.g., planning dinner for guests; handling finances)

Stage #5: Requires assistance in choosing proper clothing

Stage #6: Decreased ability to dress, bathe, and toilet independently:

- Sub-stage 6a: Difficulty putting clothing on properly
- Sub-stage 6b: Unable to bath properly; may develop fear of bathing
- Sub-stage 6c: Inability to handle mechanics of toileting (i.e., forgets to flush, does not wipe properly)
- Sub-stage 6d: Urinary incontinence
- Sub-stage 6e: Fecal incontinence

Stage #7: Loss of speech, locomotion, and consciousness:

- Sub-stage 7a: Ability to speak limited (1 to 5 words a day)

- Sub-stage 7b: All intelligible vocabulary lost
- Sub-stage 7c: Non-ambulatory
- Sub-stage 7d: Unable to sit up independently
- Sub-stage 7e: Unable to smile
- Sub-stage 7f: Unable to hold head up

(ii) Documentation of specific secondary conditions (i.e. Pressure Ulcers, UTI, Dysphagia, Aspiration Pneumonia) related to Alzheimer's Disease will support eligibility for hospice care.

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(e) Hospice Criteria for Adult Stroke and/or Coma

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria below must be present at the time of initial certification or re-certification for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of stroke. Patients must meet **(i) and (ii).**

(i) A Palliative Performance Scale (PPS) of ≤ 40.

(I) Degree of ambulation-Mainly in bed

(II) Activity/extent of disease unable to do work; extensive disease

(III) Ability to do self-care -Mainly Assistance

(IV) Food/fluid intake-Normal to reduced

(V) State of consciousness -Either fully conscious or drowsy/confused

(ii) Inability to maintain hydration and caloric intake with any one of the following:

(I) Weight loss > 10% during previous 3 months

(II) Weight loss > 7.5% in previous 6 weeks

(III) Serum albumin < 2.5 gm/dl

(IV) Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.

(V) Calorie counts documenting inadequate caloric/fluid intake.

(iii) The medical criteria for 3 listed below would support a terminal prognosis for individuals with a diagnosis of coma (any etiology):

(I) Comatose patients with any 3 of the following on day three or after of coma:

I. abnormal brain stem response

II. absent verbal response

III. absent withdrawal response to pain
IV. progressive increase in serum creatinine >1.5 mg/dl

3. Reasons for Denial
(i) Patients not meeting the specific medical criteria in this policy.
(ii) Absence of supporting documentation of progression or rapid decline.
(iii) Failure to document terminal status of six months or less.

(f) Hospice Criteria for Adult Amyotrophic Lateral Sclerosis (ALS)

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria below must be present at the time of initial certification or re-certification for hospice. ALS tends to progress in a linear fashion over time. The *overall* rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases. No *single* variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist. In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis. Examination by a neurologist within three months of assessment for hospice is required, both to confirm the diagnosis and to assist with prognosis. Patients will be considered to be in the terminal stage of ALS (life expectancy of six months or less) if they meet the following criteria (must fulfill **i, ii, *or* iii**):

(i) The patient must demonstrate critically impaired breathing capacity

(I) Critically impaired breathing capacity as demonstrated by ***all*** the following characteristics occurring within the 12 months preceding initial hospice certification:

- Vital capacity (VC) less than 30% of normal
- Continuous dyspnea at rest
- Requiring supplemental oxygen at rest P02 < 55 or 02 Sat < 89% so that Medicaid supplemental O2 criteria is met
- Patient declines artificial ventilation

(ii) Patient must demonstrate ***both*** rapid progression of ALS and critical nutritional impairment

(I) Rapid progression of ALS as demonstrated by ***all*** the following characteristics occurring within the 12 months preceding initial hospice certification:

- Progression from independent ambulation to wheelchair or bed bound status
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in ***all*** ADLs.

(II) Critical nutritional impairment as demonstrated by ***all*** the following characteristics occurring within the 12 months preceding initial hospice certification:

- Oral intake of nutrients and fluids insufficient to sustain life
- Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

(iii) Patient must demonstrate ***both*** rapid progression of ALS and life-threatening complications

(I) Rapid progression of ALS, see (ii)(I) above

(II) Life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months preceding initial hospice certification:

- Two or more episodes of recurrent aspiration pneumonia (with or without tube feedings)
- Upper urinary tract infection (pyelonephritis)
- Sepsis
- Recurrent fever two weeks after completion of antibiotic therapy

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(g) Hospice Criteria for Adult Cancer

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria below must be present at the time of initial certification or re-certification for hospice. Patients will be considered to be in the terminal stage of cancer (life expectancy of six months or less) if they meet the following criteria (**i) and (ii)** must be present:

(i) Documentation of Metastasis or final disease stage is required with evidence of progression.

(ii) Palliative Performance Scale (PPS) < 40.

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(h) Hospice Criteria for Adult Heart Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria below must be present at the time of initial certification or re-certification for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of heart disease. Medical criteria **(i) and (ii)** must be present as they are important indications of the severity of heart disease and would thus support a terminal prognosis if met.

(i) When the recipient is approved or recertified the:

(I) Patient is already optimally treated with diuretics **and** vasodilators, which may include angiotensin-converting enzymes (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, **or** evidence of treatment failure prohibit the use of ACE inhibitors **or** the combination of hydralazine and nitrates, **or** patient voluntarily declines treatment the documentation must be present in the medical records **or** with lab results and medical records submitted upon request.

(II) Patient has angina pectoris, at rest, resistant to standard nitrate therapy and are either not candidates or decline invasive procedures. This must be supported by documentation contained in the medical record.

(ii) The patient has significant symptoms of recurrent congestive heart failure (CHF) at rest, and is classified as a New York Heart Association (NYHA) Class IV:

(I) Unable to carry on any physical activity without symptoms

(II) Symptoms are present even at rest

(III) If any physical activity is undertaken, symptoms are increased

(iii) Documentation of the following factors may provide additional support for end stage heart disease:

(I) Treatment resistant symptomatic supraventricular or ventricular arrhythmias

(II) History of cardiac arrest or resuscitation

(III) History of unexplained syncope

(IV) Brain embolism of cardiac origin

(V) Concomitant HIV disease

(VI) Documentation of ejection fraction of 20% or less

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(i) Hospice Criteria for Adult Liver Disease

1. Terminal Illness Description: Coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of six months or less if the terminal illness runs its normal course.

2. Indications/Criteria: Criteria below must be present at the time of initial certification or re-certification for hospice. Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. Documentation in the record must support both **(i) and (ii)**.

(i) The patient should show ***both*** (I) and (II):

(I) Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR)>1.5

(II) Serum albumin < 2.5 gm/dl

(ii) End stage liver disease is present and the patient shows at least **one** of the following:

(I) ascites, refractory to treatment or patient non-complaint

(II) spontaneous bacterial peritonitis

(III) hepatorenal syndrome (elevated creatinine and BUN with oliguria (<400ml/day) and urine sodium concentration <10 mEq/l

(IV) hepatic encephalopathy, refractory to treatment, or patient non-compliant

(V) recurrent variceal bleeding, despite intensive therapy

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(j) Hospice Criteria for Adult Renal Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Indications/Criteria: Criteria below must be present at the time of initial certification or re-certification for hospice. Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria:

(i) ***Acute renal failure*** **(I), (II), and (III)** must be present)

(I) Creatinine clearance <10 cc/min (<15 cc/min. for diabetes)

(II) Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetes)

(III) Fractional Excretion of Sodium (FENa) > 2

(ii) ***Chronic renal failure*** **(I), (II), and (III)** must be present)

(I) Creatinine clearance <10 cc/min (<15cc/min for diabetes)

(II) Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetes)

(III) Glomerular filtration rate (GFR) < 30 ml/min

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is on dialysis.

Author: Wanda J. Davis, Associate Director, LTC Policy Advisory Unit, Long Term Care Division
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.20; and State Plan.
History: Rule effective February 13, 1991. **Amended:** Filed March 20, 2001; effective June 20, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-51-.05. Election Procedures.

(1) If an individual meets the eligibility requirements for hospice care, he or she must file an election certification statement (Medicaid Hospice Election and Physician's Certification, Form 165) with a particular hospice. An election may also be filed by a representative as defined in Rule No. 560-X-51-.02(9).

(2) An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(a) Remains in the care of a hospice.
(b) Does not revoke the election provisions under Rule No. 560-X-51-.07.
(c) Is recertified when there is a break in care.

(3) An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day subsequent benefit periods. If an individual revokes the hospice election, any days remaining in that election period are forfeited.

(4) An individual or representative may not designate an effective date that is earlier than the date that hospice care begins.

(5) A Medicaid beneficiary who resides in a nursing home may elect hospice services. The hospice must have a contract with the nursing home to delineate which

services each has responsibility to provide. A contract is necessary to clarify the details of how the nursing home and hospice will work together.

(6) If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs.

Author: Wanda J. Davis, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.24; State Medicaid Manual; and State Plan.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991 and October 1, 1993. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-51-.06. Waiver of Other Benefits.

An individual shall waive all rights to Medicaid services that are covered under Medicare for the duration of the election of hospice care for the following services:

(1) Hospice care provided by a hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice

(2) Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:

(a) Provided by the designated hospice

(b) Provided by another hospice under arrangements made by the designated hospice.

(c) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

(3) Medicaid covered services that are not related to the hospice recipient's terminal illness are not waived.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.24; OBRA '90; State Medicaid Manual; and State Plan. Rule effective February 13, 1991. Effective date of this amendment October 1, 1993.

Rule No. 560-X-51-.07. Election Revocation.

(1) An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the hospice election, any days remaining in that election period are forfeited.

(2) The hospice shall provide the Alabama Medicaid Hospice Care Program a copy of the form used to revoke the individual's election for Medicaid coverage of hospice care for the remainder of that election period.

(3) Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

Authority: Title XIX, Social Security Act; 42 C.F.R Section 418.28; State Medicaid Manual; and State Plan. Rule effective February 13, 1991.

Rule No. 560-X-51-.08. Change of Hospice.

(1) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made.

(2) To change the designation of hospice provider, the individual or representative must file a signed statement that includes the following information:

(a) The name of the hospice from which care has been received.

(b) The name of the hospice from which the individual plans to receive care.

(c) The effective date.

A copy of this statement must be provided to the hospice provider and to the Alabama Medicaid Agency.

(3) The waiver of rights as address in Rule No. 560-X-51-.06 remains in effect.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.30; State Medicaid Manual; and State Plan. Rule effective February 13, 1991.

Rule No. 560-X-51-.09. Covered Services.

(1) The following services are covered hospice services when provided by qualified personnel:

(a) Nursing care

(b) Medical social services

(c) Physician services

(d) Counseling services

(e) Short-term inpatient care

(f) Medical appliances and supplies, including drugs and biologicals

(g) Home health aide services and homemaker services

(h) Physical therapy, occupational therapy, and speech-language pathology

(i) Nursing home room and board

(2) Nursing care, physician services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.80 and 42 C.F.R. Section 418.202; State Medicaid Manual; and State Plan. Rule effective February 13, 1991.

Rule No. 560-X-51-.10. Reimbursement for Levels of Care.

(1) With the exception of payment for direct patient care services by physicians, payment is made to the hospice for all covered services related to the treatment of the recipient's terminal illness for each day during which the recipient is Medicaid eligible and under the care of the hospice regardless of the amount of services furnished on any given day.

(2) Payment for hospice care shall be in the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid hospice payment rates are based on the same methodology used in setting Medicare rates and adjusted to disregard offsets attributable to Medicare coinsurance amounts. Each rate is a prospectively determined amount which CMS estimates generally equals the costs incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. The rates will be adjusted by Medicaid to reflect local differences in wages.

(3) With the exception of payment for physician services as outlined in Rule No. 560-X-51-.11, Medicaid reimbursement for hospice care will be made at one of the four rates for each day in which a Medicaid recipient is under the care of hospice. The payment amounts are determined within each of the following categories:

(a) Routine home care. The hospice shall receive reimbursement for routine home care for each day the recipient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(b) Continuous home care. The hospice shall receive reimbursement for continuous home care when, in order to maintain the terminally ill recipient at home, nursing care is necessary on a continuous basis during periods of crises. Continuous home care is intended only for periods of crises where predominately skilled nursing care is needed on a continuous basis to achieve palliation or management of the recipient's acute medical symptoms; and only as necessary to maintain the recipient at home. A minimum of eight (8) hours per day must be provided. For every hour or part of an hour

of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

(c) Inpatient respite care. The hospice shall receive reimbursement for inpatient respite care for each day on which the recipient is receiving respite care. Patients admitted for this type of care are not in need of general inpatient care. Inpatient respite care may be provided only on an intermittent, non-routine, and occasional basis and may not be reimbursed for more than five consecutive days, including date of admission, but not date of discharge.

(d) General inpatient care. The hospice shall be reimbursed for general inpatient care for each day in which the recipient is in an approved inpatient facility for pain control or acute or chronic symptom management. Payment for total inpatient care days (general or respite) for Medicaid patients cannot exceed twenty percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during each 12-month period of November 1 through October 31.

(4) Reimbursement for drugs not related to the recipient's terminal illness may be made to the dispensing pharmacy through the Medicaid Pharmacy Program.

(5) Medicaid will not restrict hospice services based on a patient's place of residence. If a beneficiary residing in a nursing home elects the Medicaid Hospice benefit, the Medicaid Program will pay the hospice directly an established rate in lieu of payments directly to the nursing home. The payment rate will be 95% of the rate Medicaid would have paid the nursing home directly for the same patient.

Author: Priscilla Miles, Associate Director, LTC Program Management Unit.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.302; State Medicaid Manual; and State Plan.
History: Rule effective February 13, 1991. Amended: October 1, 1993. **Amended:** Filed March 20, 2001; effective June 20, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-51-.11. Reimbursement for Physician Services.

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. Group activities, which include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

(1) Payment for direct patient care services rendered by physicians employed by or working under arrangements made with the hospice may be billed by the physician

with the hospice provider indicated as the payee. Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

(2) Services provided by the patient's attending physician who is not an employee of, or receiving compensation from the hospice for services provided for the hospice, will be paid to that physician in accordance with the usual billing procedures for physicians.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.304; State Medicaid Manual; and State Plan. Rule effective February 13, 1991.

Rule No. 560-X-51-.12. Payment Acceptance.

(1) Payment made by the Medicaid program for hospice care services shall be considered payment in full.

(2) The patient or responsible party shall not be billed in full or in part for any service reimbursed under any service component of the Medicaid Hospice Care Program. Services that are not considered hospice care and non-covered Medicaid services may be billed to the individual.

(3) Co-payments may not be imposed with respect to hospice service rendered to Medicaid recipients.

(4) No person or entity, except a third party resource, shall be billed, in part or in full, for Medicaid covered services.

(5) For dually eligible recipients for whom Medicare is the primary payer for hospice services, Medicaid may be billed for coinsurance amounts for:

(a) Drugs and biologicals furnished by the hospice while the recipient is not an inpatient at 5% of the cost of the drug or biological not to exceed $5.00 per prescription.

(b) Inpatient respite care equal to 5% of the payment made by CMS for a respite care day.

Author: Priscilla Miles, Associate Director, LTC Program Management Unit.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.400 and 418.402; State Medicaid Manual; and State Plan.
History: Rule effective February 13, 1991. Effective date of this amendment October 1, 1993. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-51-.13. Third Party Liability.

(1) A third party is another insurance company or agency that may be responsible for paying all or part of the cost for medical services provided to a Medicaid recipient. Some examples of third parties are Medicare, CHAMPUS, CHAMPVA, major

medical insurance, dental insurance, cancer insurance, automobile insurance, and worker's compensation.

(2) Medicaid shall be considered the "payer of last resort." The hospice provider must bill all third parties which might pay for services provided before billing Medicaid.

(3) See Chapter 20, Third Party, for additional Third Party procedures.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.56(d); and State Plan. Rule effective February 13, 1991.

Rule No. 560-X-51-.14. Confidentiality.

(1) The provider of hospice care shall not disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient, except upon the written consent of the recipient, his attorney, or his guardian, or upon subpoena from a court of appropriate jurisdiction. See Rule 560-X-20-.05, Third Party, for additional requirements regarding release of information.

(2) The hospice must safeguard the clinical record against loss, destruction, and unauthorized use.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.52 and 418.74(6)(b); and State Plan. Rule effective February 13, 1991.

Rule No. 560-X-51-.15. Audits.

(1) The provider of hospice care shall furnish the Alabama Medicaid Hospice Care Program with requested information regarding claims submitted to the Medicaid Program and shall permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

(2) Complete and accurate medical and fiscal records that fully disclose the extent of the services and billings shall be maintained by the provider of hospice care. Said records shall be retained for the period of time required by state and federal laws.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 418.74; and State Plan. Rule effective February 13, 1991.